MDR Tracking Number: M5-04-0750-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-07-03. Date of service 10-30-02 was not filed timely per Rule 133.308((e)(1).

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits for dates of service 11-13-02 through 02-05-03 were found to be medically necessary. The unlisted modality and prolonged evaluation for dates of service 11-13-02 through 02-19-03 as well as the office visit for date of service 02-19-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, unlisted modality and prolonged evaluation.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 10-30-02 through 02-19-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION - AMENDED

Date: January 21, 2004

RE: MDR Tracking #: M5-04-0750-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the documentation supplied, it appears that the claimant injured her hand and neck from repetitive injuries sustained at work on ___. She reported to ___ for evaluation and treatment. The claimant underwent chiropractic therapy that failed and eventually led to surgery. A FCE was performed on 04/12/2002, which revealed decreased ranges of motion in her neck and wrists bilaterally. There was documentation of treatments from 10/30/2002 – 02/19/2003. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits with manipulations, unlisted modality and prolonged evaluation rendered between 11/13/2002 – 02/19/2003.

Decision

I disagree with the insurance company and agree with the treating doctor that the office visits dated 11/13/2002, 12/18/2002 and on 02/05/2003 were medically necessary. I agree with the insurance company that the remainder of therapy was not necessary.

Rationale/Basis for Decision

The supplied documentation supports a neck and wrist injury on ___. After conservative therapy failed, the claimant continued her treatment with surgery. She continued to have pain and changed jobs in order to decrease her pain. A FCE on 03/05/2002 revealed the claimant still had weaknesses and decreased range of motion due to her original injury. The therapy in question begins on 10/30/2002 and ends on 02/19/2003. Since the treatment rendered was over 2 years post-injury, any passive modalities are considered unreasonable and not medically necessary. All therapy would predominately be active care on a home exercise protocol. Since the claimant continued to have pain, monthly office visits would be considered necessary in evaluating and referring the claimant as needed.